APPEAL NO. 93100

This appeal arises under the Texas Workers' Compensation Act, TEX. REV. CIV. STAT. ANN. art. 8308-1.01 *et seq*. (Vernon Supp. 1993) (1989 Act). A contested case hearing was held in (city), Texas, on December 15, 1992, (hearing officer) presiding, to determine whether the respondent (claimant) had reached maximum medical improvement (MMI) and, if so, the date; whether claimant had any impairment and, if so, the amount; whether claimant had disability and was entitled to temporary income benefits (TIBS); and whether claimant had refused a bona fide offer of employment. The hearing officer determined that the report of the designated doctor selected by the Texas Workers' Compensation Commission (Commission) that claimant reached MMI on June 1, 1992, with an impairment rating of five percent, was contrary to the great weight of the other medical evidence; that claimant did have disability and was entitled to TIBS; and that (employer) had not made claimant a bona fide offer of employment. The carrier challenges the sufficiency of the evidence to support these determinations while the claimant urges our affirmance.

DECISION

Finding sufficient evidence to support the hearing officer's findings and conclusions, we affirm.

It is important in this case to observe at the outset that there was no disputed issue concerning the compensability of claimant's injury. Nor was there a disputed issue concerning the scope or extent of such injury, that is, whether claimant's injury was limited to her lumbosacral sprain/strain of (date of injury), or included her post-traumatic stress disorder (PTSD) and depression diagnosed on (date of injury), after her April 5, 1992 examination by the designated doctor.

Claimant, a registered nurse who worked at All Saints Hospital, testified that in March 1991 she slipped at work and injured primarily her ankle and also her back. On (date of injury), she "aggravated" her back injury by pushing heavy patient stretchers in the hospital without assistance. She testified that pushing patient stretchers was a two-person task, that she asked her supervisor for help and was told to do it alone or be fired, that she had to push 10 or 12 patients that day, and that she started having severe pain that day and "that is when [she] really hurt her back." At the time of the hearing she said she was still under the care of Dr. Q, an osteopath, for her back injury, and taking medications and undergoing a work hardening program; that she was still under the care of Dr. A, a neurologist, for blackouts and headaches; and that she was still under the care of Dr. B a psychiatrist, for her PTSD and depression. Claimant testified she was taking Flexeril, a muscle relaxer, Darvocet for pain, Xanax for anxiety, and Zoflot for depression, and that these drugs made her drowsy and reduced her mental and physical alertness.

Claimant also testified that not only had none of her doctors released her to return to work but none had even suggested or given her any indication she was fit to return to work, not even to light duty. In fact, her "treating doctor" told her she absolutely could not return

to work. She stated that, at the carrier's request, she was examined by Dr. D on November 11, 1991, and that he recommended she undergo chronic pain management and rehabilitation programs. Pursuant to those recommendations, claimant said she was learning pain management techniques from Dr. B and receiving work hardening through Dr. Q. Claimant acknowledged that Dr. D stated in his report she could return to work performing sedentary duty for four hour shifts at first and then working up to eight hour shifts, but said she had not been offered a job involving four hour shifts of sedentary work. She agreed that in March 1992 employer had written her offering her a charge nurse job at employer's nursing home working shifts from 2:00 p.m. to 10:00 p.m., Monday through Friday, but indicated she did not respond because her doctor had not released her to return to work. She also testified that the responsibilities of the offered charge nurse position would include, as necessary, helping other personnel lift or move patients, that it would be unsafe for her to perform charge nurse duties given her current mental condition and the effects of the medications she was taking, and that she has not received a job offer within the doctor's restrictions (presumably those of Dr. D). She stated she is currently unemployed, cannot return to work due to her back injury and its complications of severe depression and anxiety, and is presently unable to return to any type of work at her preinjury wage.

BM, employer's safety director, testified that in March 1992, employer wrote claimant offering the charge nurse position at the nursing home, that it was a "modified duty job," which she equated to "light duty," and that it was "based on whatever E.B.I. (an unidentified entity, possibly the carrier's adjustor) had probably taken from Dr. D." She said claimant was fully qualified for the job, which paid claimant's regular wage, but that claimant made no effort to respond to the offer. She also said she was aware that none of claimant's doctors had released her to return to work and she understood that Dr. B had stated that claimant was presently "disabled" due to her PTSD and depression, and was receiving treatment and medications which Dr B felt would affect claimant's ability to do her job. Ms. M said she was also aware that Dr. Q shared that opinion. However, Ms. M explained that employer's March 1992 job offer was based on the medical evidence then available. She also said that the designated doctor's report indicated claimant could return to "light duty" on June 1, 1992. This witness opined that employer's written offer "could be read" to include only four hours of work within the stated 2:00 p.m. to 10:00 p.m. period. Employer has not made a subsequent job offer to claimant.

On April 13, 1992 claimant was examined by Dr. S, the designated doctor. Claimant said she took x-rays and doctors' reports to that examination and had her mother accompany her. When her mother offered those documents to Dr. S, he would not take them, indicating he did not need them. Claimant conceded on cross-examination that she did not know for certain that Dr. S did not already have copies of those documents. She felt Dr. S report was "totally fabricated" in that he never even touched her during the examination. She said that after his April 13th examination, Dr. S estimated her MMI date

as June 1, 1992 and that she had not subsequently provided him with records from Dr. Bonham who first saw claimant on (date of injury) and diagnosed her severe depression and PTSD.

Dr. Q records reveal that an August 29, 1991 CT scan showed bilateral facet degenerative changes at L4/L5 and L5/S1 and mild generalized disc bulging at L4/L5; that a lumbar spine MRI of September 1, 1991 showed desiccation of the L5/S1 intervertebral discs, mild disc space narrowing at the L5/S1 level, and mild midline disc bulging at L4/L5; that Dr. Q diagnosed, variously, lumbosacral sprain and strain, and cervical strain, to be treated conservatively; and that claimant's estimated return to work date remained "undetermined" through November 18, 1992. In an April 14, 1992 report, Dr. Q stated he totally disagreed with Dr. Ds suggestion that claimant had chronic pain syndrome. He also totally disagreed with Dr. Ds opinions on future treatment, impairment rating, and recommendations for future return to work. In May 1992 Dr. Qu stated that claimant had been attending a work hardening program three times a week for the past three weeks and he recommended she remain in that program through June 1, 1992 and then be reevaluated. Claimant had initially commenced a work hardening program in January 1992 but it was discontinued because of the pain in her neck and lower back.

Dr. As records indicate that with claimant's history of severe lower back pain radiating into her lower extremities, he performed electromyelograms on October 4, 1991 and on February 4, 1992. The findings were normal. He obtained an MRI of claimant's brain in February 1992 following claimant's reported seizure two weeks earlier and the results were normal. He attributed claimant's loss of consciousness episode to a vasovagal reaction secondary to her severe low back pain, assessed claimant as having post- traumatic low back pain radiating to both lower extremities, and prescribed Elavil for pain control. He also noted her complaints of episodes of feeling off balance and nearly fainting, secondary to her pain. While claimant denied being depressed, she indicated she was tired of the pain, the insurance company demands, and of worrying about her career. On April 1, 1992, Dr. A found lumbosacral tenderness on exam, increased the Elavil and also prescribed Xanax. On May 6, 1992, claimant continued to complain to Dr. A of severe radiating low back pain, weakness in her legs, and near fainting episodes. Dr. A added a diagnosis of post-traumatic stress syndrome with anxiety and depression, changed medications, and referred her for an examination by Dr. B. Dr. Q, who had also referred claimant to Dr. A for evaluation of her headache and "black out spells," agreed with Dr. A referral of claimant to Dr. Bonham for psychiatric therapy "to help [claimant] cope with the injury and the limitations it has placed on her life." On July 27, 1992, claimant visited Dr. A who again found lumbosacral tenderness and about 45 degrees of limitation in her lumbar flexion. He continued his prior diagnosis and adjusted her medications. On October 13, 1992, Dr. A found lumbosacral and left upper hip tenderness, about 20 degrees of limitation in lumbar flexion, and noted that claimant's current medications included Relafen, Xanax, Pemlor, Flexeril and Darvon. He continued his earlier diagnosis and adjusted her medications.

Claimant had visited Dr. N on January 23, 1992, and he diagnosed "degenerative disc disease - lumbar," and "lumbarsacral radiculitis of lower extremities," and indicated her prognosis and anticipated date for return to work were "undetermined." Dr. N saw claimant again on September 10, 1992, diagnosed "displacement intervertebral disc," and stated her anticipated date of return to work was "undetermined." On October 18, 1992, Dr. N wrote what can only be described as a scathing letter, apparently sent to the carrier, which asserted that claimants' complaints of pain were "very legitimate" and that she does not fall into the category of a fraudulent claimant.

Dr. B records contain an initial psychiatric evaluation of (date of injury), which noted claimant's severe chronic pain and which contained a diagnosis of depression and chronic pain syndrome but no personality or developmental disorder. He stated that claimant's prognosis was guarded, noting that she is "a very bright lady in a great deal of distress and has done all she could on her (own) and is still getting worse." Dr. B report of August 4, 1992, stated that claimant has "severe Bio-chemical Depression and Post Traumatic Stress Disorder" which "are directly as a result of the on the job injury," and that she was "totally disabled" as a result of the depression and PTSD. According to Dr. B deposition upon written questions, taken on December 11, 1992, claimant was first seen by Dr. B on (date of injury), and she presented with a history of an on-the-job injury, serious depression, and chronic pain. Dr. B diagnosed PTSD. He expressed opinions, based upon reasonable medical and/or psychiatric probability, that claimant's PTSD and depression resulted from her work- related injury of (date of injury), and that such injury was a producing cause of her PTSD and depression. After being provided with the definition of MMI (Article 8308-1.03(32)(A)), Dr. B opined that claimant had not yet reached MMI "for all of her injuries resulting from the injury in the course and scope of her employment of (date of injury)." Dr. B also stated his opinions that claimant has "sustained a disability" as that term is defined in Article 8308-1.03(16), and that she was "totally disabled" at the time of his initial exam and remains so. At the hearing, the carrier declined the opportunity to submit deposition cross questions to Dr. B.

Carrier submitted the November 5, 1991 report of Dr. D, a specialist in physical medicine and rehabilitation, who conducted an independent medical exam at carrier's request. Dr. D impression was chronic pain syndrome which he said was indicated not only by the persistence of the pain, rated as quite intense by claimant, but also by the pain's pervasive effect on claimant's life and its limitation of her functioning. Dr. D felt that claimant was not a candidate for surgery or for physical therapy or chiropractic care. He recommended an "interdisciplinary chronic pain management/rehabilitation program," and also commented that claimant's pain was "real." Dr. D also stated that if claimant "does not pursue treatment dealing with her chronic pain syndrome, I would say that she is at maximum medical benefit as there are
no other treatments that . . . are likely to produce a lasting benefit to her." He also said that

because claimant was not six months post injury, she would not meet the American Medical Association impairment guides criteria for assessing an impairment rating for disc problems. As for claimant's ability to return to work, when asked for an opinion based "strictly upon the objective findings," Dr. D said that "[o]n that basis [I] would have to say that she could return to at least sedentary duty, although I recommend that she begin with 4 hours per day and progress gradually up to a full 8-hour day. . . . My main concern would be that her intense focusing upon her pain would make it unlikely for her to be successful in returning to work."

Dr. S, the designated doctor and an orthopedic surgeon, submitted to the Commission a Report of Medical Evaluation (TWCC-69) with an attached report dated April 13, 1992. In Item 14 addressing whether claimant had reached MMI, the "No" block was checked and the "estimated date" for MMI was stated as "6-1-92" together with the assignment of a five percent impairment rating. The carrier introduced a second TWCC-69, signed by Dr. S, which checked the "Yes" block in Item 14 indicating claimant had reached MMI on "6-1-92" with a five percent impairment rating. The record was not developed as to when the second TWCC-69 was signed. Certainly, there was no indication Dr. S further examined claimant or reviewed Dr. Bs records before signing the second TWCC-69. Thus, the record is not clear as to whether Dr. Ss second TWCC-69 was also only a mere estimate of the MMI date. According to Dr. S's narrative, he saw claimant on April 13, 1992 "for evaluation of her lower back." He stated that claimant had lumbosacral strain and he recommended she continue with her work hardening program for another six weeks. His opinions were as follows:

> In my opinion, this patient will reach [MMI] on 6-1-92 and she can go to light duty work at that time progressing into regular duty work two weeks later with no pushing or pulling. In my opinion, this patient will have 5 percent partial permanent disability in terms of physical impairment of the function of the whole body.

Both TWCC-69 forms stated that the five percent impairment rating was for the lumbar spine.

Carrier also introduced a letter from employer to claimant, dated March 30, 1992, advising that "modified duty work" was available at employer's nursing home and that "[t]he hours are 2:00 p.m. to 10:00 p.m., Monday through Friday." The letter stated that the position was that of charge nurse responsible for the supervision of nurses and for overseeing general operations, that the position was "sedentary with walking," and involved no patient assisting, lifting or transfers, that claimant's preinjury wage would be paid, and that "[a]ll tasks will be within the restrictions provided by [claimant's] physician."

The hearing officer concluded that all of claimant's medical evidence, including Dr. Bs deposition (which included his records of claimant) and Dr. Ns reports, was sufficient to rebut the presumptive weight accorded the designated doctor's report, and, therefore, that

claimant did not reach MMI on June 1, 1992, and there was no sufficient basis for the assignment of an impairment rating. Articles 8308-4.25(b) and 8308-4.26(g) provide that if the Commission selects the designated doctor, that doctor's report shall have presumptive weight and that the Commission shall base its determinations of MMI and impairment rating on such report unless the great weight of the other medical evidence is to the contrary.

We agree with the hearing officer and find sufficient support in the evidence for her factual findings and legal conclusions respecting the MMI and impairment rating issues. Dr. Ss report plainly stated he examined claimant on April 13, 1991 to evaluate her lower back. Claimant was not seen and diagnosed by Dr. B until (date of injury). Nowhere in his report does Dr. S even allude to claimant's PTSD and depression. Dr. B's diagnosis of claimant's PTSD and depression and his expert opinions that such mental trauma injuries were caused by and directly resulted from claimant's (date of injury) work related injury are uncontroverted in the record. As claimant advised the hearing officer, the Commission's Appeals Panel has previously considered the issue of whether an injured employee can be certified to have reached MMI when such employee's work related injuries involve both physical and mental trauma injuries and the certifying doctor has considered only the physical injury. *See* Texas Workers' Compensation Commission Appeal No. 92452, decided October 5, 1992, and Texas Workers' Compensation Commission Appeal No. 92641, decided January 4, 1993. That case also involved a low back physical injury followed by PTSD.

We also find sufficient support in the record for the hearing officer's determination that claimant has disability. Neither Dr. Q, Dr. A, Dr. N, nor Dr. B had released claimant to return to work of any type. Claimant testified, with support in her medical records, that she continues to take a variety of medications, some of which result in her drowsiness and reduction in mental and physical alertness. She testified that she would regard as "unsafe" her return to work as a charge nurse considering the side effects of her medications.

We also find sufficient support in the evidence for the conclusion that the employer did not make a bona fide offer of employment to claimant. As employer's safety director testified, the basis for the letter, with its references to a sedentary position, to no pushing or pulling, and so forth, was the November 5, 1991 report of carrier's doctor, Dr. D. Tex. W.C. Comm'n, 28 TEX. ADMIN. CODE § 129.5(b) (Rule 129.5(b)), addresses the content of written offers of employment. To constitute a bona fide offer of employment, such a letter must clearly state, among other things, that "the employer is aware of and will abide by the physical limitations under which the employee or his treating physician have authorized the employee to return to work, . . ." (Emphasis supplied.) The carrier asserts it "is fully aware of the Appeals Panel's previous holdings that only the claimant or treating physician can set the parameters for light duty under Rule 129.5(b)," citing Texas Workers' Compensation Commission Appeal No. 91023, decided October 16, 1991, Texas Workers' Compensation Commission Appeal No. 92184, decided June 25, 1992, and Texas Workers' Compensation Commission Appeal No. 92297, decided August 19, 1992. Carrier then

asserts that such reading of Rule 129.5(b) "is wrong and should be reconsidered," urging that the Appeals Panel "transforms an evidentiary weight rule into a procedural trigger." We remain persuaded by the logic of our earlier decisions.

The decision is affirmed.

Philip F. O'Neill
Appeals Judge

CONCUR:

Joe Sebesta
Appeals Judge

Thomas A. Knapp
Appeals Judge